COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2010-11

MANUAL

SECTION I:

ELIGIBILITY

EFFECTIVE: JULY 1, 2010

THE FOLLOWING MAJOR CHANGES HAVE BEEN MADE TO THE FY 2010-11 ELIGIBILITY SECTION

Section 1.02 Provider's Statement of Responsibilities

Section 7.06 Expenses - No longer used to calculate CICP income

Section 7.07 In-Kind- No longer used to calculate CICP income

Section 7.09 Resources – Removed consideration of real property and business equity

Section 7.14 Personal Vehicle Usage Deduction

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ARTICLE I. PROGRAM OVERVIEW

The Colorado Indigent Care Program (CICP) distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under Medicaid or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are indigent. The CICP Administration issues procedures to ensure the funding is used to serve the indigent population in a uniform method. Any significant departure from these procedures will result in termination of the contract with, and the funding to, a health care provider. The legislative authority for this program was originally enacted in 1983 and can currently be found under 25.5-3-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent."

Section 1.01 Provisions Applicable to Providers (8.903)

Providers eligible for participation in the CICP must meet the following minimum criteria:

- Licensed or certified as a general hospital, community health clinic or maternity hospital (birth center) by the Department of Public Health and Environment.
- Assure that emergency care is available to all CICP clients throughout the contract year.
- If the provider is a hospital, the hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services as Medicaid clients. In the case where a hospital is located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.

Section 1.02 Provider's Statement of Responsibilities

Providers participating in the CICP shall:

1. Treat all clients with respect and with consideration for the client's dignity and privacy.
2. Inform clients of how to express opinions, compliments or concerns and how to make a complaint without fear of reprisal.
3. Strive to provide timely resolutions to the client's complaints or concerns.
4. Protect the privacy and confidentiality of the client's health and financial records.

5. Offer clients information on all treatment options and allow clients to participate in decisions regarding his or her health care.

6. Notify the client of the availability of sign language and interpreter services in accordance with applicable laws and regulations, when such services are necessary.

7. Ensure the availability of program information – applications, informational materials, forms and brochures.

8. Prohibit discrimination based on race, color, national origin, sex, age or disability.

9. Upon request, provide applicants with copies of all signed worksheets and documents.

10. Explain to the client or guardian that discounted services may vary and that a rating based on financial resources will determine their portion of the bill.

Section 1.03 Services Provided Under the CICP (8.902)

Health care services provided to CICP clients must be medically necessary, as determined by the CICP provider. Medical necessity is defined at 10 CCR 2505-10, Section 8.076.1.8., and means a good or service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, injury, or disability. It may also include a course of treatment that includes mere observation or no treatment at all. The good or service must be:

i) Provided in accordance with generally accepted standards of medical practice in the United States;

ii) Clinically appropriate in terms of type, frequency, extent, site, and duration;

iii) Not primarily for the economic benefit of the provider or for the convenience of the client, caretaker, or provider; and

iv) Performed in a cost effective and most appropriate setting required by the client's condition.

All health care services normally provided at the hospital and/or clinic are regularly available at a discount to CICP clients unless the provider sets a standardized policy that limits available services. Providers must offer emergency services at a discount. The CICP Administration has granted waivers to limit medical services to a specific area or county; however, the waivers do not exclude the provider from supplying required emergency care at a discount to any CICP client, even if that client resides outside the provider's service area.

If a CICP provider agrees to accept a client transfer from another CICP provider, the client must be provided discounted services from both providers. It is the receiving provider's decision to charge an additional copayment for the service provided. It would be appropriate to charge an

inpatient copayment if the client was being admitted to a hospital and the client had only paid an outpatient copayment at the primary provider.

Statute requires that CICP providers prioritize care in the following order:

1. **Emergency care:** Treatment for conditions of an acute, severe nature which are life, limb or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 25.5-3-103, C.R.S.

2. **Urgent care:** Treatment needed because of an injury or serious illness that requires immediate treatment because the client's life or health may be in danger.

3. Any other additional medical care that may include:

   a. Pharmaceutical services: Some CICP providers provide pharmaceutical services. Providers that offer this service will only fill prescriptions under the CICP discount that are written by doctors on their staff (or a doctor that has contracted at that facility). CICP providers cannot provide pharmaceutical services under the CICP discount unless there is a written mutual agreement between the doctor and the CICP provider.

   b. Inpatient psychiatric care and inpatient drug and alcohol services for up to 30 days per client throughout each state fiscal year (July 1 through June 30).

   c. A provider may subcontract with a third party provider to furnish additional services not available at the CICP provider's facility; i.e., ambulance, specialist's services or pharmaceuticals. The contract must stipulate that the CICP Administration is not a party to the contract and not involved in the negotiations. The third party provider will submit charges, other payments, patient liability and other data as required under the contract directly to the CICP provider. In addition, the third party provider will be reimbursed by the CICP provider and not directly by the Department.

   d. Discounted Prenatal Program: The CICP Prenatal Pricing Program has been discontinued; however, providers are encouraged to utilize provider flexibility and create such a program at their facility, establishing a copayment they feel is adequate to encourage clients to obtain prenatal services. Remember: A provider may charge an additional inpatient copayment for the delivery service, but it is inappropriate to charge an additional copayment for the baby upon delivery. A CICP client must always be charged the appropriate CICP copayment, never a global preset delivery charge. For example, a CICP client cannot be required to pay an additional amount for delivery over and above the copayment amount.

Section 1.04 Excluded Services (8.902 E)

The following services are not reimbursable through the CICP:

1. Elective surgeries that are not medically necessary

2. Nursing home care

3. Chiropractic services

4. Sex change surgical procedures

5. Cosmetic surgery

6. Experimental and non-FDA approved treatments

7. Non-urgent dental services

8. Court-ordered procedures, such as drug testing

9. Abortions, except as specified in Sec. 25.5-3-106, C.R.S.

10. Mental health services as a primary diagnosis in an outpatient or clinic setting; the CICP can reimburse for the services if they are a secondary diagnosis

11. Prescription drugs included in the definition of Medicare Part-D are excluded from CICP eligible clients who are also eligible for Medicare

Section 1.05 Health Coverage Plans (8.900)

The CICP is not health insurance. The Colorado Department of Regulatory Agencies, Division of Insurance, defines a health coverage plan as a policy, contract, certificate or agreement of coverage offered to individuals. An insurance contract shall include a list of procedures and benefits covered under the policy. An insured individual shall be entitled to receive a contract and/or evidence of coverage as approved by the Insurance Commissioner as defined in 10-16-102, C.R.S.

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. Medically indigent persons receiving discounted health care services from qualified health care providers are subject to certain limitations and requirements. The CICP makes "it possible to use state funds to partially reimburse providers for services given to the state's non-Medicaid medically indigent residents. Therefore, medically indigent persons accepting medical services from this program shall be subject to the limitations and requirements imposed in this article," Section 25.5-3-102 C.R.S. The CICP is not a health coverage plan as defined in Section 10-16-102 (22.5) C.R.S.

Section 1.06 HIPAA (Health Insurance Portability and Accountability Act)

The Department has determined that the CICP is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the CICP is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not

considered a covered entity under HIPAA. The CICP provider is the covered entity and shall comply with all requirements under HIPAA regarding the rights of the clients they serve. Decisions made to protect the privacy rights of clients are solely those of the covered entity. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a health care provider or client.

ARTICLE II. CLIENT ELIGIBILITY FOR CICP (8.904)

Section 2.01 Overview of Requirements

The **"CICP Eligibility Section"** contains the program guidelines for determining eligibility. The CICP Administration refers to eligibility determination as "the rating process." The CICP Administration intends that the rating process be uniform across the state. The rating process takes a "snapshot" of an applicant's financial resources as of the date the rating takes place and a signed Application is obtained. Ratings usually occur on the initial date of service. **Ratings are retroactive for services received up to 90 days prior to Application, or if there for applicants with other health insurance coverage, when the third party payer has adjudicated claim.** Therefore, when an applicant who has received services applies for the CICP, the applicant is applying for a discount on already incurred medical charges. Providers may extend the deadline for special circumstances under a policy determined and set by the provider.

Before individuals are found eligible for the CICP, they are referred to as "applicants." After individuals are determined eligible for the CICP, they are referred to as "clients."

In general, all applicants aged 18 and older must:

1. Sign an affidavit indicating their citizenship status;
2. Provide **one** approved document to demonstrate that they are lawfully present in the country;
3. Be a resident of the State of Colorado;
4. Furnish a Social Security number (or documentation that they have applied for one); and
5. Meet all other CICP eligibility requirements (related to income, etc.).

Section 2.02 Instructions for Completing the Application

The CICP Client Application (Application) appears in the Appendix section. When completing the Application, the provider must obtain as much documentation as possible to support the applicant's financial status. Documentation assures that State funds are used appropriately. Except in the event of an emergency, an Application can be denied for non-compliance if the client refuses to provide required information or documentation.

The provider should schedule an appointment with the applicant to complete the Application within 45 days after the date of service and must make a reasonable attempt to complete the Application within 90 days after the date of service. It is in the provider's best interests to ask first-time clients whether or not they have received a CICP rating.

Clients are responsible for notifying the provider's billing office if they have received a CICP rating from another CICP facility. Clients must report their CICP eligibility rating to the provider within 90 days of service. If a client fails to report his or her CICP eligibility rating within 90 days, the provider is not obligated to provide a discount.

Section 2.03 Emergency Application (8.904 G)

Sometimes it may not be practical to rate an applicant using the regular CICP Application process. For example, an individual seen in an emergency room because of an injury may be unable to provide all of the information or documentation required by the usual Application process. For emergency situations, complete the following steps.

1. Use the regular CICP Application, ***but check "EMERGENCY"*** at the top (right corner) of the Application;

2. Ask the applicant to respond verbally to all questions and to sign the Application; and

3. Assign a CICP rating based on the verbal information provided.

By following the above steps, you have created an "Emergency Application." Effective July 1, 2008, an Emergency Application is good for one episode of service in an emergency room and any subsequent service (such as in inpatient hospital stay) related to the emergency room episode. The subsequent service must immediately follow the emergency room service to qualify as part of an emergency episode. Treatment must be continuous to be considered part of the same emergency episode. If the client receives any care other than the emergency room visit that is not related to the emergency room episode, you must request the client to submit documentation to support all figures on the Emergency Application OR complete a new CICP Application. If the documentation submitted by the client does not support the verbal information, you must complete a new CICP Application. If the client does not submit any supporting documentation or complete a new Application upon the request of the provider, the provider shall use the information contained in the Emergency Application.

An individual can only complete an Emergency Application once a year. Any requests for medical care in the emergency room after the initial date of service or episode must include a completed Application accompanied by the requested documentation. Any applicant who meets the definition of homeless (see Section IV of this manual, CICP Regulations Section 8.907.B.a., for the definition of homeless) is not restricted to completing an Emergency Application only once a rating year.

Providers must allow a client to complete an Emergency Application when the client seeks emergency services, even if the client does not reside in the geographical area where the provider typically offers CICP discounted health care services.

All CICP clients must have an initial rating which is usually valid for one year. However, initial ratings may change for various reasons. The most common method of changing a client's rating is "client re-rating." See Section 8.02 Client Re-rate (8.906.B.), for more complete information.

Section 2.04 Other Provider's Rating

Providers are not required to accept each other's rates if a provider believes the rate was determined inaccurately or that the person was rated incorrectly. If a discrepancy exists, providers are asked to contact each other and arrive upon the correct rating.

Section 2.05 Provider Flexibility

Each provider is encouraged to establish policies and procedures specific to their facility which do not directly contradict this manual. The CICP Administration is available for informational queries of a general nature. Providers are responsible for determining eligibility. Not all circumstances in determining client eligibility are covered in this manual and the manual is not meant to be all-inclusive.

Section 2.06 Liquid Asset Spend Down

Liquid Asset Spend Down is a provision which enables clients to qualify for the CICP discount even if their current liquid assets exceed the eligibility standards. At their discretion, providers may implement a standardized policy to allow clients who are not currently eligible to "spend down" liquid resources (i.e. bank accounts, stocks) so the client can become eligible for a CICP discount. The amount that liquid assets exceed the eligibility standard (250% of the Federal Poverty Level) can be applied to the current medical bill (paid to the provider). The remainder of the medical bill is then discounted under the CICP. The client is still responsible for the CICP copayment.

Example: A client has employment income of $16,000 per year and has a bank account of $12,500. With a family size of 1, the Family Size Deduction is $2,500, so Equity Resources is $10,000 ($12,500 – 2,500 = $10,000). Total family financial status is $26,000 ($16,000 + $10,000 = $26,000), with no allowable deductions. This person is currently ineligible for a CICP discount, but is unable to pay a current medical bill of $25,000. Using the Liquid Asset Spend Down provision, the client is eligible for a CICP discount at $24,500 (family size of 1, at 250% of Federal Poverty Level), so liquid assets need to be reduced by $1,500 ($26,000 – $24,500 = $1,500). The $1,500 is applied to the current medical bill of $25,000 and paid to the provider as cash. The remaining medical bill is $23,500 ($25,000 - $1,500 = $23,500). The client is now eligible for the CICP discount, with a total family financial status of $24,500 ($16,000 employment income and $8,500 in equity and resources) and the remaining portion of the medical bill can be discounted. The client is still responsible for the CICP copayment at the I-rating. When reporting information on the CICP Summary Spreadsheet, the provider may record the total bill of $25,000 and the client spend down of $1,500 as a third party payment.

ARTICLE III. MEDICAID and CHILD HEALTH PLAN *PLUS* (8.904 F)

Section 3.01 Screening for Medicaid and Child Health Plan *Plus* (CHP+)

Providers must screen CICP applicants for Medicaid and CHP+ prior to assigning a CICP rating. This is beneficial for both providers and clients because, under Medicaid and CHP+, providers receive higher reimbursement and clients receive more benefits and pay lower copayments. The Provider Compliance Audit requires verification that the applicant was determined not categorically eligible for Medicaid or CHP+.

A checklist to screen for eligibility in CHP+ and Medicaid has been developed and is located in Section VI of the Provider Manual: Client Application, Section I of the CICP Application. The provider must have all potentially eligible individuals apply for Medicaid or CHP+ unless he or she would not be eligible due to categorical restrictions. The reason(s) for not directing an applicant to apply for Medicaid or CHP+ must be documented.

Section 3.02 Temporary CICP for CHP+ Eligible Individuals

Individuals eligible for CHP+ are enrolled on a prospective basis, effective on the CHP+ Application date. Therefore, individuals who are waiting to be enrolled in CHP+ and/or have incurred charges at a CICP provider in the 90 days prior to the CHP+ application date may be considered for CICP eligibility on a temporary basis.

Section 3.03 Denial of Medicaid or CHP+ Eligibility

If the applicant appears to meet the eligibility criteria for CHP+ or any of the Medicaid eligibility categories, below, a denial letter from CHP+ or the local county Department of Human or Social Services must be received.

An individual who applies for Medicaid or CHP+ and is denied eligibility for categorical reasons, is eligible for CICP coverage upon receipt of the denial letter. The provider must retain a copy of the denial letter with the CICP Application as documentation.

A letter from CHP+ or the local county Department of Human or Social Services indicating voluntary withdrawal or denial due to refusal to submit complete documentation is not sufficient proof that the patient has applied for CHP+ or Medicaid and been denied.

If a CICP applicant does not fit in any of the Medicaid eligible categories or meet the requirements for CHP+, do not ask for a denial letter. In general CICP clients who have furnished Medicaid or CHP+ denial letters in past years and whose financial condition or family size has not changed do not need to submit another letter. However, on May 1, 2010, eligibility for parents of children on Medicaid increased to 100% of the Federal Poverty Level and eligibility for CHP+ increased to 250% of the Federal Poverty Level. If current CICP clients may now meet the new income levels for Medicaid or CHP+, upon re-rating the provider must re-screen for CHP+ and Medicaid eligibility and direct potentially eligible individuals to apply for Medicaid or CHP+.

Section 3.04 Medicaid

Medicaid is a state and federally funded program that pays for medical services for low-income families and individuals. Medicaid is a program for the categorically needy, meaning that an individual or family must fall below a certain income/resource limit and qualify for one of the following categories:

Section 3.05 Medicaid - Categorically Needy Families and Children

1931 MEDICAID (AFDC)	Children and families qualify for Medicaid-only benefits under certain AFDC guidelines that were in effect on July 16, 1996. Effective May 1, 2010, parents of Medicaid children with annual incomes up to 100% of the Federal Poverty Level are eligible for 1931 Medicaid.
Baby Care Kids Care	This applies to pregnant women and to children up to age 6 in families with incomes below 133% of the Federal Poverty Level and for children up to age 19 at 100% of the Federal Poverty Level.
Foster Care Children	This category covers persons less than 21 years of age for whom a county is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions, or in subsidized adoptive homes prior to the final decree of adoption.

- There are a number of application sites at which families may apply for Medicaid-only benefits. The family may also apply at the local County Department of Social Services or a Presumptive Eligibility (PE) Site.

- Medicaid and Child Health Plan *Plus* (CHP+) Presumptive Eligibility (PE) is immediate temporary medical coverage for children 18 and under and pregnant women that have applied for Medicaid or CHP+ and appear to be eligible. The Medicaid/CHP+ PE period begins on the date the client applies and continues for no less than 45 days. Only a certified site can determine presumptive eligibility for Medicaid/CHP+ PE. A list of PE sites can be located at www.colorado.gov/hcpf. The application completed can be used to apply for Medicaid-only benefits for members of the household.

Section 3.06 Medicaid - Elderly & Persons with Disabilities

Old Age Pension (OAP) - Medicaid	Most recipients of Colorado Old Age Pension who are between 60-64 years of age and disabled or over 65 years of age (disabled not a factor over age 65) are eligible for Medicaid and are under 74.6% of the Federal Poverty Level in 2009. These individuals are not eligible for CICP.
Old Age Pension – State Only (Health and Medical Care Program	Recipients of Colorado Old Age Pension who are not eligible for the full range of Medicaid benefits. Individuals covered under OAP Health and Medical Care Program (State Only) are eligible for CICP.
SLMB (Special Low Income Medicare Beneficiaries)	State pays toward the premium of Part B Medicare only and recipients are eligible for CICP.
QMB-ONLY (Qualified Medicare Beneficiaries)	State pays Medicare Part B premiums (and in some cases Part A premiums) and recipients are not entitled to the full range of Medicaid benefits. State is liable for Medicare deductibles and coinsurance charges only for services covered and approved by Medicare. Clients are eligible for CICP.
Medicare-Medicaid-QMB:	Entitled to the full range of Medicaid benefits, including pharmaceuticals. Also entitled for Medicaid reimbursement of Medicare deductibles, coinsurance and premiums. Recipients are not eligible for CICP.
Medicare-Medicaid:	Primarily, this applies to some individuals eligible for Medicaid as the result of a need for long-term care in a nursing facility or its alternative. Medicaid is not liable for Medicare deductibles and coinsurance for these clients unless the service provided is a regular Medicaid benefit. Clients are not eligible for CICP.
HCBS & Nursing Home Patients	Disabled individuals needing long term care whose incomes do not exceed 300% of the Supplemental Security Income (S.S.I.) level. Clients are not eligible for CICP.

Home Care Allowance – Cash Assistance	The program provides a monthly cash payment for the purchase of in-home services to low-income, frail elderly or disabled clients, enabling them to remain in their own homes as long as possible.
Adult Foster Care – Cash Assistance	The program provides a monthly cash payment for the purchase of 24-hour supervised non-medical care in an AFC facility for individuals who cannot live alone but don't need medical supervision.

SSI BENEFITS: Residents who are over 65 years of age, blind or disabled, including children, should apply for Supplemental Security Income at their local Social Security office. As soon as they are awarded SSI, they automatically will be enrolled in Medicaid.

SSI also provides coverage for:

Persons from age 0 to 64 who are unable to work due to a disability expected to continue longer than 12 months.

Persons with an illness or disability that prevents gainful employment and is expected to result in their death.

SSDI BENEFITS: Under Social Security, workers are considered disabled if they have a severe physical or mental condition that prevents them from working. The conditions must be expected to last for at least 12 months or to result in death. SSDI benefits are based on previous 40 quarters of earned income history. Once benefits begin, they continue for as long as the worker is disabled and can't work. The disabled worker and eligible family members receive checks each month. ***(Source: Social Security Administration, SSA Publication No. 05-10080, March 1999)***

Section 3.07 OAP Health and Medical Care Program

As noted in Section 3.06, individuals covered under the OAP Health and Medical Care Program (OAP State Only) are eligible for discounted health care services under the CICP. If an OAP Health and Medical Care Program client does not wish to apply for discounted health care services under CICP, providers may submit their write-off charges to the CICP. Write-off charges submitted to the CICP for OAP Health and Medical Care Program clients equal the provider's total charges, less payment from the Department's fiscal agent, less any copayment due from the client, less any other third party payments.

Billing information should be submitted to the CICP in your regular quarterly and annual Summary Reports as detailed in the Data Collection section of this manual (see Section II: Data Collection, Article III – Data Collection System – Summary Format). Providers must retain the

eligibility verification for the date of service from the Department's CMERS, FaxBack or Web Portal systems along with billing records for audit purposes.

This policy is intended solely as a mechanism for CICP providers to submit legitimate write-off charges to the CICP for services provided to OAP Health and Medical Care Program clients; to be eligible for discounted services under the CICP with appeal rights, these clients must complete and sign a CICP Application.

Section 3.08 Completing the Medicaid Ineligibility Codes

For each household member on Section I of the CICP Application, please check the appropriate code that determines why an applicant is not eligible for Medicaid:

- **A** Received Medicaid denial letter, attach letter to Application
- **B** Code is no longer used
- **C** Applicant is not a U.S. citizen, has not been a legal resident for at least 5 years, or does not have refugee status
- **D** Applicant is no longer pregnant and beyond post-partum
- **E** Transitional Medicaid benefits have been discontinued
- **F** Individual no longer receiving SSI or SSDI
- **G** Does not meet Medicaid's definition of disability or incapacity and is under 65 years of age

Section 3.09 Child Health Plan *Plus* (CHP+)

CHP+ is a state and federal health insurance program for children ages 0 through 18 and pregnant women with family incomes at or below 250% of the Federal Poverty Level. CHP+ allows spend downs for medical bills, insurance premiums, day care, elder care, alimony payments and child support.

Section 3.10 CHP+ - Other Health Coverage

A child or pregnant woman will be found ineligible for CHP+ if the individual:

1. Is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or
2. Is eligible for Medicaid; or
3. Is a member of a family that is eligible for health benefits coverage under a State health benefits plan based on a family members' employment with a public agency in the State; or
4. Has had coverage under an employer plan with at least a 50% employer contribution during the past three months, unless the individual lost health coverage due to a change or loss in employment, or the employer eliminated insurance coverage. There is a three month waiting period for possible eligibility in this case.

Section 3.11 How to Contact CHP+

Website www.CHPplus.org

Telephone: 1-800-359-1991.

Section 3.12 Completing the CHP+ Ineligibility Codes

For each household member on Section I of the CICP Application, please check the appropriate code that determines why an applicant is not eligible for CHP+:

1 Received CHP+ denial letter, attach letter to Application

2 Individual is eligible for Medicaid

3 Applicant is not a U.S. citizen and has not been a legal resident for at least 5 years, or does not have refugee status

4 Individual has other primary health insurance coverage

5 Individual was insured under an employer plan with at least 50% employer coverage in the past 3 months, unless dropped due to change in employment status or employer eliminated coverage

6 A member of the family is eligible for health benefits coverage under State health benefits plan or public agency in the state (i.e., employed by the State of Colorado)

7 Does not meet age requirement, Adult, 19 years of age or older and is not pregnant

ARTICLE IV. HEALTH INSURANCE INFORMATION (8.904 I)

Applicants with other medical insurance may still qualify for CICP. Therefore, Applications should be completed for individuals with other medical insurance. In some cases, other medical insurance may not cover certain medically necessary benefits or applicants may have used all of their benefits. Applicants may not know if their other medical insurance will cover certain charges until after the CICP Application time limit of 90 days has expired**.** Charges for services received up to 90 days prior to Application, or in the case of applicants with other health insurance coverage, when the third party payer has adjudicated claim, can be reported to the CICP. Applicants cannot be denied CICP if they have other insurance, and **it is the responsibility of the provider's collection/claims office to bill all other medical insurance companies first before reporting the charges to CICP.**

Section 4.01 Health Insurance

Obtain all information related to the insurance policy and attach a copy of the policy or insurance card to the Application. Required information includes the name of the insurance company, the address where the medical claim forms must be submitted, policy number and any other information determined necessary. The clinic or hospital will bill the commercial health insurance policy first for all medical expenses incurred. Unpaid medical expenses will be billed to the CICP minus the health insurance copayment or the CICP copayment, whichever is lower.

Providers can report contractual write-offs required under some commercial health insurance contracts in total charges and are only required to report payments due from the commercial health plan in third party liability. Patient liability is the payment due from third party insurance, including Medicare. This is not payments actually received, but the amount owed by the client's primary insurance. CICP will reimburse for contractual adjustments; therefore, do not include these adjustments as liabilities or as payments due.

If an applicant receives **Veterans Benefits** they may also receive CICP benefits provided that the following is met:

- Recipient is unable to receive a specific medical service or treatment from the Veterans Administration.
- Veterans Benefits have been verified. Call 1-877-222-8387 to verify health benefits.
- If the veteran has primary insurance they must utilize this first. The Veterans Administration requests that a veteran not utilize their Veterans Benefits if they have primary insurance.

Resource types:

- Group Health Insurance
- Military Health Insurance
- Medicare
- Workers' Compensation
- Veterans Benefits
- HMO
- Medicaid
- COBRA
- Other commercial health plans

Section 4.02 Medicare Bad Debt

A provider can declare the percentage of Medicare deductibles or coinsurance not reimbursed by the client or a state program as Medicare Bad Debt. If an individual qualifies for a state low-income program (such as CICP), the debt may be deemed uncollectible without applying a reasonable collection effort (such as turning the debt over to a collection agency). Please contact the CICP Administration if you desire copies of these Medicare Regulations.

The maximum a provider can collect from a CICP eligible client is the CICP copayment, even if that client has another primary insurance such as Medicare.

Reimbursement Examples:

Example #1: Client is Eligible for CICP and Pays CICP Copayment

Medicare Coinsurance	$1,000	
Minus CICP Client Copayment	$100	
Equals Amount Charged to CICP	$900	
Minus Amount Reimbursed by CICP	$90	(assumes reimbursed at 10% of Charges)
Equals Amount Added to Bad Debt	$810	
Minus Amount Reimbursed by Medicare	$648	(assumes reimbursed at 80% of Bad Debt)
Equals Total Uncompensated	$162	
Total Amount Received by Provider	$838	($100 + $90 + $648)

Example #2: Client is Eligible for CICP and Fails to Pay CICP Copayment

Medicare Coinsurance	$1,000	
Minus CICP Client Copayment	$100	
Equals Amount Charged to CICP	$900	
Minus Amount Reimbursed by CICP	$90	(assumes reimbursed at 10% of Charges)
Plus CICP Client Copayment Bad Debt	$100	
Equals Amount Added to Bad Debt	$910	
Minus Amount Reimbursed by Medicare	$720	(assumes reimbursed at 80% of Bad Debt)
Equals Total Uncompensated	$190	
Total Amount Received by Provider	$810	($90 + $720)

Section 4.03 Health Insurance Billing Examples:

Example #1: Medicare Third Party Payment with CICP as Secondary Payer

$150.00	Medical bill - Total Charges Billed to Medicare
-$100.00	Minus Payment Due from Medicare
$50.00	Equals Hospital Charges Remaining
$50.00	Hospital Charges Remaining
-$25.00	Minus Client Copayment
$25.00	***Allowable Write-Off Charges Reported to CICP***

Charges Reported to CICP

Total Charges	Patient Liability	3rd Party Liability	Write-Off Charges
$150.00	$25.00	$100.00	$25.00

Example #2: Simple Third Party Payment with CICP as Secondary Payer

$150.00	Medical bill - Total Charges Billed to Client's Commercial Health Plan
-$100.00	Minus Payment Due from Client's Commercial Health Plan
$50.00	Equals Hospital Charges Remaining
$50.00	Hospital Charges Remaining
-$25.00	Minus Client Copayment
$25.00	***Allowable Write-Off Charges Reported to CICP***

Charges Reported to CICP

Total Charges	Patient Liability	3rd Party Liability	Write-Off Charges
$150.00	$25.00	$100.00	$25.00

Section 4.04 Medical Insurance

Charges to the CICP are secondary to all insurance programs.

1. Group and Individual Health Insurance Applicants may be eligible for CICP coverage. The provider is required to bill the resource listed before submitting the claim to CICP.

2. Workers' Compensation applicants can participate in the CICP. However, the provider must bill Worker's Compensation before billing the CICP.

3. Victim's Compensation is the only third party coverage billed after CICP coverage. Victim's Compensation may be used to cover the client's CICP copayment.

4. HMO (Health Maintenance Organization) clients can participate in CICP; however, out

of network services are not covered. Services not available in the commercial HMO insurance policy and deemed medically necessary can be billed to CICP minus the insurance copayment paid by the client.

5. COBRA (Consolidated Omnibus Budget Reconciliation Act) COBRA benefits are continued health plan benefits provided by the employer. Terminated employees or those who lose coverage because of reduced work hours may purchase the group coverage for themselves and families for a limited period of time. They have 60 days to accept coverage or lose all rights to these benefits. Once COBRA coverage is chosen, they will be required to pay for their coverage.

6. Medicare eligible clients have CICP coverage for amounts and services NOT covered by Medicare. Medicare has three main types of coverage: (1) Medicare Part A is inpatient hospital coverage available to all people over age 65; (2) Medicare Part B, outpatient services, requires clients to pay a monthly premium; and (3) Medicare Part D is for prescription drug coverage. Some Medicare beneficiaries qualify for Medicaid as a Qualified Medicare Beneficiary (QMB). If an applicant has QMB coverage, they can participate in the CICP.

7. CICP can be used to satisfy the deductible or coinsurance for primary insurance, including Medicare. Clients are responsible for the CICP copayment or the copayment of the primary insurance, whichever is lower. The deductible or coinsurance should be included in Total Charges billed to the CICP. The only entry into Client Liability is the copayment required.

Section 4.05 Subsequent Insurance Payments

If clients receive coverage under the CICP, and their insurance subsequently pays for services, or if the client is awarded a settlement, the provider must document any subsequent reimbursement received when submitting their summary data information. See Article VII, Previous Charged Claim Adjustments, of the Billing Section on how to document these payments.

Section 4.06 Grants

Grants from foundations to CICP clients from non-profit, tax-exempt or charitable foundations specifically for CICP client copayments are not considered other medical insurance or income. The provider must honor these grants and not count the grant as a resource or income.

ARTICLE V. CLIENT APPLICATION (8.904 H)

Section 5.01 Name

This is the person who is responsible for paying incurred charges. Any non-minor household member can be the responsible party. If an applicant is deceased, the executor of the estate or a family member can complete the Application on behalf of the applicant. The executor or family member completing the Application will not be responsible for any copayments incurred on behalf of the deceased member.

Section 5.02 Applicant Address

Applicant's address refers to the residence of all family members included in the rating. All members included under this rating must live at this address. This address cannot be a business address or an empty lot. The family address must be the primary place where the family resides. See "Colorado Resident" under Section 5.17 for more information on the family's primary home.

Homeless Clients are exempt from client copayments, income verification requirement, verification of denied Medicaid benefits and providing proof of residency when completing the CICP Application.

A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

Section 5.03 Household Member's Name (8.904 H)

Record the name of each family member who has received care, will receive care through the CICP, or will be included in the family size calculation for Line 12, Section II of the Application.

Determining family members to include on the Application. The following information will help determine if a family member can receive care through the CICP and/or be counted in family size. The first table shows family members for whom financial support and dependency does not need to be demonstrated. The second table shows family members for whom at least 50% of their financial support must be demonstrated before they can be counted in the family for purposes of inclusion on the CICP Application.

FAMILY MEMBERS FOR WHOM FINANCIAL SUPPORT DOES NOT NEED TO BE DEMONSTRATED

• Spouses (including common-law marriage)	• Minor children (see Sec. 5.04 Relationship Codes)	• Adopted minor children
• Unborn children	• Minor grandchildren	• Parents
• Grandparents		

All other family members must receive at least 50% of their support from the responsible party in order to be included on the CICP Application for the family. Proof of support includes the family member being listed on the prior year's tax return as a dependent and/or proof of support expenses through cancelled checks or copies of money orders.

FAMILY MEMBERS FOR WHOM FINANCIAL SUPPORT MUST BE DEMONSTRATED

• Step-children	• Step-grandchildren	• Parents-in-law
• Step-parents	• Adult brothers and sisters	• Adult children
• Adult grandchildren	• Brothers-in-law and sisters-in-law	• Sons-in-law and daughters-in-law
• Cousins	• Nephews and nieces	• All others not specifically listed in the first table, above

Section 5.04 Relationship Codes

Enter the appropriate Relationship Code number:

1 Self **2 Spouse** **3** Child **4** Stepchild **5** Other

1. **Married Couples** BOTH spouses must be included on the Application. Married couples will receive the same CICP rating unless one of the spouses is Medicaid eligible or an undocumented immigrant; in which case, both are still included in family size.

   A married couple means that the couple is legally married. Proof of marriage is a marriage license or marriage certificate. Married couples may keep their finances separate, including payments for medical care. However, according to the Joint Liability for Family Expenses, 14-6-110, C.R.S., "the expenses of the family and the education of the children are chargeable upon the property of both husband and wife, or either of them and in relation thereto they may be sued jointly or separately." If one spouse does not want to give the necessary financial information, rate the family based on the best

information available. However, inform the non-compliant spouse that according to Colorado law spouses are responsible for each other's medical charges.

Married couples wishing to separate or divorce must provide legal documentation of the separation or the dissolution of marriage to be considered separate for CICP eligibility. For those who have not yet officially filed for a legal separation or dissolution of marriage, but intend to do so, or for those who have filed but an official court decree has not yet been issued, a letter from their attorney verifying their status will suffice.

2. **Common Law Marriage** - If a man and woman meet the requirements for common law marriage, the same rules apply as with married couples (Section 5.04(1)). All five of the following requirements must be met for a common-law marriage in Colorado:

   a. It must be the INTENT of both parties to be husband and wife

   b. Both parties must be 18 years of age or older

   c. Both parties must be free to marry (single, widowed or legally divorced)

   d. Both parties must live together

   e. Both parties, by reputation, must claim to be married

   - If one or more of these conditions are not met, a couple living together is not a "family" for CICP ratings. This means both partners must complete separate applications.

   - As with married couples, the wife does not have to take the husband's last name for a common-law marriage.
   - Providers may request an affidavit of Common Law Marriage signed by both parties.

3. **Same Sex Marriage:** Colorado law does not recognize same sex marriages; therefore, partners of same sex marriages must complete separate Applications. This includes common law marriages between persons of the same sex. The only exception to this exclusion is if one member is a bona fide dependent of the other (based on legal documentation provided). In these cases, count both partners in family size**.**

4. **Minors (under the age of 18):** Minors should not be rated separately from their parents or guardians unless they are emancipated. Exception to this requirement is made for the following reasons:

   a. A minor who has a child and obtains medical care for the child (the minor parent is legally responsible for the cost of care).

   b. Examination and treatment for sexually transmitted diseases.

   c. Examination and treatment for alcohol and/or drug addiction.

d. Obstetrical and gynecological procedures, birth control procedures, supplies or information. If the parents of a minor child who is pregnant have insurance to cover that child, but the insurance excludes pregnancy of the minor and the parents are claiming financial responsibility for her, that child is not considered emancipated and should be rated based on the parent's income. If the parents do not qualify for the program, then she cannot be covered under CICP.

e. Voluntary mental health services, but only if the minor is fifteen years old or older.

f. Treatment or testing for HIV.

g. Confidential Teen Services Program - Minors in this program are rated without consideration of their parent's income under the conditions described. Therefore, when minors seek services and claim no income other than the parents' income, they will be rated category A. If the minor declares personal income (e.g., part-time job), that income will be used in determining the rating. If the rating is higher than category A, the higher rating will prevail.

5. **Emancipated Minors:** "Emancipated juvenile", pursuant to 19-2-511, C.R.S., means "a juvenile over fifteen years of age and under eighteen years of age who has, with the real or apparent assent of the juvenile's parents, demonstrated independence from the juvenile's parents in matters of care, custody and earnings. The term may include, but shall not be limited to, any such juvenile who has the sole responsibility for the juvenile's own support, who is married, or who is in the military."

6. **Communal Groups:** Do not include unrelated members of religious orders and communal living groups on the same Application. Each unrelated member must complete a separate Application.

7. **Family Members Outside of Colorado:** If a family member lives outside of Colorado, including in a foreign country, that individual is not a Colorado resident. However, count the member in family size if the responsible party provides more than 50% of the member's support and claims the member as a dependent for income tax purposes.

8. **Family Members Eligible for SSI, Child Support and Foster Care:** Include family members receiving cash assistance. Family members receiving only cash assistance can receive care under the CICP if they are not Medicaid eligible.

9. **Family Members Eligible for Medicaid:** Family members eligible for Medicaid cannot receive care under the CICP, but can be included in the family size calculation**.**

10. **Additional situations involving children:**

a. Unborn Children: Include the unborn child/children of a pregnant woman in family size on the family's Application.

h. Children of Divorced Couples - Include children of divorced parents on the custodial parent's Application. If the parents have joint custody, the parents must decide which

parent will include the children for the CICP rating purposes. If parents with joint child custody cannot agree on which parent will include the child on the CICP Application, the income tax records of the parent with the child listed as a dependent should prevail.

i. Children in School - Include children age 18 years or older who are attending high school or college and whose parents support them, on the parents' Application. DO NOT count any income the child may earn.

j. Disabled Children - Include a child with disabilities, regardless of age, on the parent's Application if the parents support the child. If the disabled child is Medicaid eligible, the child cannot receive medical care through the CICP, but should be included in family size. Exception: An adult child with a disability and gainfully employed must complete a separate Application.

k. Adult Children - Adult children (defined as 18 years or older) living at home can be counted in the family unit only if the entire family is listed on the Application, and the adult child receives 50% of their support from the responsible party. If the adult child has an income, the amount must be included in determining the family financial status. Adult children may submit their own Application if they desire, but in this case would not be included on the family Application for income or household size.

l. Newborns use the mother's Social Security number up to the age of 1 year.

m. Family Members Eligible for CHP+ - Any family member eligible for CHP+ may only receive discounted services on a temporary basis under the CICP, but is included in the family size calculation for the CICP.

Section 5.05 Date of Birth

You must enter the date of birth for all family members included in family size or receiving discounted services through the CICP, except for unborn children.

Section 5.06 Medicaid State ID Number

If any family member listed receives Medicaid, record the state Medicaid ID number on the Application.

Section 5.07 Social Security Number

All applicants must have a Social Security Number. You must enter the social security number for all family members receiving discounted medical care through the CICP on the CICP Application. The only exception to this is for unborn children. If an applicant does not have a social security number, effective July 1, 1997, a receipt of Application for a Social Security number must be received at the time of CICP Application. A CICP provider may choose to write only the last four digits of the applicant's Social Security Number on the CICP card.

Section 5.08 Residency Code

To qualify for the CICP an applicant must be lawfully present in the United States and either a Colorado resident, a documented legal immigrant or a migrant worker.

The CICP has established residency codes to use with the Application. The client must record one of the following residency codes for each family member.

1 Colorado Resident & U.S. citizen
2 Colorado Resident & documented legal immigrant (*includes August 1996*)
3 Migrant farm worker & U.S. citizen
4 Migrant farm worker & documented legal immigrant
5 Non-resident, counted in family size only
6 Medicaid eligible, counted in family size only
7 Counted in family size only

If family members are non-residents (residency code - 05) or eligible for Medicaid (residency code - 06), they cannot receive care under the CICP but can be included in family size. Family members who are eligible for CICP, but do not want to be covered under CICP may be counted in family size if they receive 50% of their support from the responsible party (residency code – 07).

1. Determining the CICP Residency Code

To determine which residency code to record on the Application, use the three steps outlined below for each family member applying for the CICP. All applicants must meet steps 1 and 2 to comply with the CICP's residency requirements.

a. Step 1: Determine if the applicant is lawfully present using the guidelines listed in Section 6.09 below. If the applicant is lawfully present and is a U.S. Citizen or documented legal immigrant, go to step 2. If the person is not a U.S. Citizen or a documented legal immigrant, the person cannot receive discounted care through the CICP, but can be used to determine family size.

b. Step 2: Determine if the applicant meets ***one*** of the following:

   i. The applicant is a Colorado resident (see "Colorado Resident" under Section 5.17) *OR*

   ii. The applicant is a migrant worker according to the criteria outlined under "Migrant Workers"

c. Step 3: Record the residency code for each family member.

Section 5.09 Lawful Presence

During the 2006 and 2007 legislative sessions House Bill 06S-1023 and HB 07-1314 were passed and directed the Department of Revenue to establish rules to ensure that recipients of

public benefits demonstrate that they are legally residing in the United States. The Department of Revenue promulgated "Rules for Evidence of Lawful Presence" at 1 CCR 201-17, effective August 1, 2007. In order to comply with these requirements, the Colorado Indigent Care Program (CICP) amended its rules pertaining to the Application process, effective January 1, 2008.

All first-time applicants and applicants re-applying to receive discounted health care services aged 18 and older must sign the "Affidavit for Lawful Presence, Colorado Indigent Care Program" and provide an approved document that demonstrates they are lawfully present in the United States.

The Department redesigned the CICP Affidavit for Lawful Presence to comply with the new rules guiding evidence of lawful presence. This version of the affidavit is to be used for all applicants beginning January 1, 2008. A copy of the Affidavit is included in Section VI of this manual. The various types of documents that can be accepted to prove lawful presence can be found on the back of this affidavit. In order to complete this affidavit the applicant must do the following:

1. **Indicate Citizenship Status.** The applicant must indicate on the Affidavit whether he/she is a U.S. citizen OR whether he/she is a legal permanent resident, or otherwise lawfully present in the United States.

2. **Sign the Affidavit.** Each applicant must sign the top portion of the Affidavit and indicate that they are either a U.S. citizen, or otherwise lawfully residing in the United States. A family member or authorized representative may do this for a deceased client.

   The Affidavit must be signed by each applicant within a household who is 18 years of age or older. Household members who do not apply in person must also sign the affidavit. Providers are not required to directly witness an applicant's signature. Therefore, a blank affidavit may be sent to a non-present applicant. The signed Affidavit may be returned to the provider by mail, fax or hand-delivered to the provider's facility.

In order to prove lawful presence the applicant must do the following:

1. **Applicants Submit One Document.** To meet the lawful presence requirement, each applicant must provide one and only one acceptable document from the list of all acceptable documents printed on the reverse side of the Affidavit for Lawful Presence. Within this list of acceptable lawful presence documents none are "preferred" over others. All are equally acceptable. Citizens of the United States may present any one of the documents numbered 1 through 29 listed below and also on the reverse side of the Affidavit. Applicants demonstrating lawful presence in the country who are not U.S. citizens may furnish any document numbered 30 through 51 listed below and also found on the reverse side of the Affidavit.

2. **Providers Establish Lawful Presence—Not Identity.** The new rules pertaining to public benefits require only the establishment of lawful presence—not identity. Thus, it

is not necessary for an applicant to provide a document with a photograph. Notwithstanding, many of the acceptable documents listed on the reverse side of the affidavit do display a photograph of the holder.

3. **Original Documents.** Lawful presence documentation may be accepted from the applicant, the applicant's spouse, parent, guardian or authorized representative in person, by mail or facsimile. In general, applicants must present original documentation. Notarized copies are not acceptable. However, providers shall accept copies of an applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.

   Providers shall develop procedures for handling original documents to ensure that the documents are not lost, damaged or destroyed. Providers shall develop and follow procedures for returning or mailing original documents to applicants within five business days of receipt.

Applicants who are U.S. citizens must provide <u>one</u> of the following documents to meet the lawful presence requirement. (The numbering sequence of these documents corresponds to the number assigned to these documents on the reverse side of the Affidavit.)

1. Colorado Driver's License
2. Colorado Identification Card
3. Driver's License or State Identification Card issued in one of the following approved states:

   (Alabama, Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Virginia, West Virginia and Wyoming.)

4. United States Military Identification Card or Military Dependents' Identification Card
5. United States Coast Guard Merchant Mariner Card
6. Native American Tribal Document
7. Birth Certificate from any state, the District of Columbia or any United States territory
8. United States Passport
9. Report of Birth Abroad of a United States Citizen (FS-20)
10. Certificate of Birth issued by a foreign service post (FS-545)

11. Certification of Report of Birth (DS-1350)

12. Certification of Naturalization (N-55- or N-570)

13. Certificate of Citizenship (N-560 or N-561)

14. U.S. Citizen Identification Card (I-97)

15. Northern Mariana Identification Card (for births prior to November 3, 1986)

16. Statement by a U.S. Consular Officer certifying that the individual is a U.S. citizen

17. American Indian Card with classification code "KIC" identifying members of the Texas Band of Kickapoos

18. Religious records recorded in one of the fifty states, the District of Columbia or U.S. territories issued within three months after birth showing that the birth occurred in such jurisdiction and the date of the birth or the individual's age at the time the record was made

19. Evidence of civil service employment by the U.S. government before June 1, 1976

20. Early school records showing the date of admission to the school, the child's date and place of birth and the names' and places of birth of the parents

21. Census record showing name, U.S. citizenship or a U.S. place of birth or age of applicant

22. Adoption Finalization Papers showing the child's name and place of birth in one of the 50 states, D.C. or U.S. territories. Where the adoption is not finalized and the State or other jurisdiction listed above in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency showing the child's name and place of birth in one of such jurisdictions. The source of the information must be an original birth certificate and must be indicated in the statement.

23. Any other document that establishes a U.S. place of birth or in some way indicates U.S. citizenship

24. Documents for Collectively Naturalized Citizens from Puerto Rico (PR), the U.S. Virgin Islands (VI), or Northern Mariana Islands (NMI), formerly part of the Trust Territory of the Pacific Islands (TTPI):

    a. Puerto Rico

        i. Evidence of birth in PR on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or PR on January 13, 1941; or

        ii. Evidence that the applicant was a PR citizen and the applicant's statement that he or she was residing in PR on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

b. U.S. Virgin Islands
    i. Evidence of birth in the U.S. Virgin Islands (VI) and the applicant's statement of residence in the U.S., a U.S. possession, or the U.S. VI on February 25, 1927; or
    ii. The applicant's statement indicating residence in the U.S. VI as a Danish citizen on January 17, 1917 and that he or she did not make a declaration to maintain Danish citizenship; or
    iii. Evidence of birth in the U.S. VI and the applicant's statement indicating residence in the U.S., U.S. Possession or Territory or the Canal Zone on June 28, 1932.
c. Northern Mariana Islands (formerly part of the Trust Territory of the Pacific Islands)
    i. Evidence of birth in NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or
    ii. Evidence of TTPI citizenship in the NMI since before November 3, 1981(NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did owe allegiance to a foreign state on November 4, 1986 (NMI local time); or
    iii. Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

25. Applicants with Derivative U.S. Citizenship
    a. Applicant born abroad to two U.S. citizens:
        i. The applicant shall present evidence of U.S. citizenship of the parents and the relationship of the applicant to the parents, and the evidence that at least one parent resided in the U.S. or an outlying possession prior to the applicant's birth.
    b. Applicant born abroad to a U.S. citizen parent and a U.S. non-citizen national parent:
        i. The applicant shall present evidence that one parent is a U.S. citizen and the other is a U.S. non-citizen national, evidence of the relationship of the applicant to the U.S. citizen parent and the evidence the U.S. citizen parent resided in the U.S., a U.S. possession, American Samoa or Swain's Island for a period of at least one year prior to the applicant's birth.
    c. Applicant born out of wedlock abroad to a U.S. citizen mother:
        i. The applicant shall present evidence of U.S. citizenship of the mother, evidence of the relationship to the applicant and, for births on or before December 24, 1952, evidence that the mother resided in the U.S. prior to the applicant's birth or, for births after December 24, 1952, evidence that the mother had resided, prior to the child's birth, in the U.S. or a U.S. possession for a period of one year.
    d. Applicant born in the Canal Zone or the Republic of Panama:

i. The applicant shall present a birth certificate showing birth in the Canal Zone on or after February 26, 1904 and before October 1, 1979 and evidence that one parent was a U.S. citizen at the time of the applicant's birth; or

ii. A birth certificate showing birth in the Republic of Panama on or after February 26, 1904 and before October 1, 1979 and evidence that at least one parent was a U.S. citizen and employed by the U.S. government or the Panama Railroad Company or its successor in title.

e. All other situations where an applicant claims to have a U.S. citizen parent and an alien parent, or claims to fall within one of the above categories but is unable to present the listed documentation:

i. If the applicant is in the U.S., refer him or her to the local Department of Homeland Security (formerly known as the Immigration and Naturalization Service, or INS) office for determination of U.S. citizenship; or

ii. If the applicant is outside the U.S., refer him or her to the State Department consular office for a U.S. citizenship determination.

26. Adoption of a foreign-born child by a U.S. citizen

a. If the birth certificate shows a foreign place of birth and the applicant cannot be determined to be a naturalized citizen under any of the above criteria, refer the applicant to the local Department of Homeland Security office for a determination of U.S. citizenship.

27. U.S. citizenship obtained by marriage

a. The applicant shall present evidence that she was married to a U.S. citizen before September 22, 1922, or

b. If the husband was an alien at the time of their marriage, that the husband became a U.S. citizen before September 22, 1922.

c. If the marriage was later terminated, the woman shall demonstrate that she resided in the U.S. at the time it was terminated and that she has continued to reside in the U.S.

28. Waiver requested from the Department of Revenue
(See Section 6.09(1).)

29. Written self-declaration or third-party declaration
(See the optional section on the bottom portion of the Affidavit for a self-declaration form that may be used by applicants.)

Additional clarification is provided below which pertains to acceptable lawful presence documentation for U.S. Citizens:

- Drivers' Licenses Drivers' licenses and state identification cards issued in Colorado and other acceptable states (see the reverse side of the affidavit for a list of acceptable states) must be valid. This means they must be current and not expired. If a hole is punched in an otherwise acceptable driver's license, for evidence of lawful presence purposes, the license is deemed acceptable.

- Passports Current and expired United States passports are permissible for demonstrating lawful presence. Limited passports issued for less than five years are not acceptable, even if they are not expired.

- Presumed Genuine In general, any document presented from the acceptable list of documents for U.S. citizens, (see numbers 1 through 29 on the reverse side of the "Affidavit for Lawful Presence, Colorado Indigent Care Program" or listed above), shall be presumed genuine unless there is a reasonable basis for questioning the authenticity of the document.

- Do Not Use SAVE Documents pertaining to U.S. citizens cannot be verified through the Systematic Alien Verification for Entitlements (SAVE) web-based verification information system application. This system only applies to non-U.S. citizens.

Applicants who are not U.S. citizens must provide <u>one</u> of the following documents to meet the lawful presence requirement. (The numbering sequence of these documents corresponds to the number assigned to these documents on the reverse side of the Affidavit.)

1. "Green Card" (a.k.a. Alien Registration Receipt Card), Department of Homeland Security Form I-551 for aliens lawfully admitted for permanent residence

2. "Green Card" (a.k.a. Alien Registration Receipt Card), Department of Homeland Security Form I-551 with the code CU6, CU7 or CH6 for Cuban or Haitian entrants

3. Unexpired Temporary I-551 Stamp in a foreign passport or on a Department of Homeland Security Form I-94 for aliens lawfully admitted for permanent residence

4. Unexpired temporary I-551 stamp in a foreign passport or on Department of Homeland Security Form I-94 with the code CU6, CU7 or CH6 for Cuban or Haitian entrants

5. Department of Homeland Security Form I-94 with a stamp showing admission under Section 203(a)(7) of the Immigration and Nationality Act for aliens granted conditional entry

6. Department of Homeland Security Form I-94 annotated with a stamp showing admission under Section 207 of the Immigration and Nationality Act for refugees

7. Department of Homeland Security Form I-94 with a stamp showing admission for at least one year under Section 212(d)(5) of the Immigration and Nationality Act for aliens paroled into the U.S. for at least one year. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement.)

8. Department of Homeland Security Form I-94 annotated with stamp showing grant of asylum under section 208 of the Immigration and Nationality Act

9. Department of Homeland Security Form I-94 with a stamp showing parole as a "Cuban/Haitian Entrant" under Section 212(d)(5) of the Immigration and Nationality Act

10. Employment Authorization Card, Department of Homeland Security Form I-688B annotated 274a.12(a)(3) for refugees

11. Employment Authorization Card, Department of Homeland Security Form I-688B annotated 274a.12(a)(5) for asylees

12. Employment Authorization Card, Department of Homeland Security Form I-688B annotated 274a.12(a)(10) for aliens whose deportation or removal was withheld

13. Employment Authorization Card, Department of Homeland Security Form I-688B annotated "A3" for aliens granted conditional entry

14. Employment Authorization Document, Department of Homeland Security Form I-765 for refugees

15. Employment Authorization Document, Department of Homeland Security Form I-766 annotated "A3" for refugees or aliens granted conditional entry

16. Employment Authorization Document, Department of Homeland Security Form I-766 annotated "A5" for asylees

17. Employment Authorization Document, Department of Homeland Security Form I-766 annotated "A10" for aliens paroled into the U.S. for at least one year

18. Grant letter from the Asylum Office or U.S.C.I.S. for asylees or a Grant letter from the Department of Health and Human Services granting refugee status to human trafficking victims

19. Refugee Travel Document, Department of Homeland Security Form I-571

20. Order from an immigration judge showing deportation withheld under Section 243(h) of the Immigration and Naturalization Act as in effect prior to April 1, 1997, or removal withheld under Section 241(b) (3) of the Act.

21. For aliens who have been battered or subjected to extreme cruelty, see Attachment 5, Exhibit B, at U.S. Attorney General Order No. 2129-97. The documentation for Violence Against Women Act self-petitioners is the Department of Homeland Security-issued "Notice of Prima Facie Determination" or "Notice of Approval".

22. Waiver requested from the Department of Revenue
(See Section 6.09(a).)

Section 5.10 Expired or Missing Documents from Non-U.S. Citizens

1. Expired Documents or No Documents If an applicant who is not a U.S. citizen presents expired documents or is unable to present any documentation evidencing his or her immigration status, the provider should refer the applicant to the local Department of Homeland Security office to obtain documentation of lawful presence status.

2. G-845 Document Verification Request In unusual circumstances involving applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the applicant can provide an alien registration number, the provider may file U.S.C.I.S. Document Verification Request Form G-845, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status. To obtain the current G-845 Document Verification Request form, go to www.uscis.gov and enter G-845 in the search box.

3. Receipt for Replacement Document If an applicant has lost a document and presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, the provider should file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify lawful presence status.

Section 5.11 Options for Applicants without Acceptable Documentation

1. **Request Waiver from Department of Revenue** Applying for a "Request for Waiver-Restrictions on Public Benefits" from the Colorado Department of Revenue authorizes the Department of Revenue to verify evidence of lawful presence for the applicant.

   a. **Who May Apply:** Any applicant, regardless of citizenship status, who does not provide a document permissible for establishing lawful presence may apply for a "Request for Waiver-Restrictions on Public Benefits" from the Colorado Department of Revenue.

   b. **Where to Find the Waiver Form:** For convenience, this Waiver may be found on-line at the CICP website under "Lawful Presence Information HB 06S-1023".

   c. **How to Apply:** The Waiver may be completed by the applicant or the applicant's representative. Applicants are not required to apply for this waiver in person. The applicant may mail, fax, e-mail, or hand-deliver this form to the Department of Revenue. The Request for Waiver must be accompanied by all documents that the applicant is able to produce to assist in the verification of lawful presence.

   d. **Affidavit of Lawful Presence:** Applicants using the waiver process must still complete the "Affidavit of Lawful Presence, Colorado Indigent Care Program" form.

   e. **Approved Waivers:** Unless the Department of Revenue provides the provider or applicant written notification of denial, providers are to assume the Request for Waiver is approved.

   f. **Special Information for Non-U.S. Citizens:** Applicants requesting a waiver who are not U.S. citizens should be made aware of the following, which is excerpted directly from The Department of Revenue's "Rules for Evidence of Lawful Presence" at 1 CCR 201-17, effective August 1, 2007.

3.1.6 Waivers are assumed to be permanent, but may be rescinded and cancelled if, at any time, the Department becomes aware of the Applicant's violation of immigration laws. Upon making a decision to rescind and cancel a waiver, the Department will notify the Applicant and the appropriate County Department of Human Services.

3.1.6.1 Individuals whose waivers are rescinded and cancelled shall have the right to appeal such decision by the Department. Individuals may appeal by requesting a hearing within thirty days of the waiver being rescinded or cancelled by making a written request for hearing to the Hearings Section of the Department at 1881 Pierce St. #106, Lakewood, CO 80214.

3.1.6.2 The Hearings Section shall hold the hearing in accordance the provisions of the State Administrative Procedure Act and the provisions of Title 42 of the Colorado Revised Statutes.

3.1.6.3 The only issue at hearing shall be whether the applicant has violated immigration laws.

3.1.6.4 The hearing officer shall issue a written decision within fifteen (15) business days of the completion of the hearing, and shall constitute final agency action, and is subject to judicial review as provided by § 24-4-106, C.R.S.

3.1.7 Waivers issued by the Department since August 1, 2006, but prior to approval of this rule, will continue in effect unless otherwise rescinded or cancelled by the Department, as authorized in Section 3.1.6.

2. **Self-Declaration of Lawful Presence:** Signing a self-declaration is a valid, acceptable way of establishing lawful presence for purposes of receiving discounted health care services under the CICP.

   a. **Who May Self Declare:** U.S. citizens and non-citizen nationals may self-declare that they are lawfully residing in the United States. Non-citizen nationals are defined in federal regulations as individuals from American Samoa, Swains Island, or Northern Mariana Islands.

   b. **Who May Not Self Declare:** Non-U.S. citizens may not self-declare that they are lawfully residing in the country.

   c. **Where to Find the Self-Declaration Form:** The Self-Declaration form is found under the optional section located at the bottom of the "Affidavit for Lawful Presence, Colorado Indigent Care Program" form.

Section 5.12 Non-Discrimination and Special Assistance

1. **Non-Discrimination:** CICP providers shall not discriminate against applicants on the basis of race, national origin, gender, religion, age or disability.

2. **Special Assistance:** If an applicant has a disability that limits the applicant's ability to provide the required evidence of lawful presence, the provider shall assist the individual to obtain the required evidence. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the applicant may provide the required documentation; or referring the client to other agencies or organizations which may be able to provide assistance.

   Additional assistance shall also be provided to applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance. Examples of additional assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the applicant.

   The provider is not required to pay for the cost of obtaining required documentation. The provider shall document its efforts of providing additional assistance to the client and retain such documentation in the Application file.

Section 5.13 Administrative Procedures for Documents from U.S. Citizens

1. **Indication of Documents Verified:** Providers are to check the box on the "For Eligibility Use Only" section of the Affidavit indicating which document the applicant has provided for demonstrating evidence of lawful presence.

2. **Retain Copy of Document:** A photocopy of the lawful presence document presented should be retained in the applicant's file.

3. **Exception Process for Clients Reapplying:** If a U.S. citizen reapplies for CICP with the same provider, it is not necessary to make a new copy of their lawful presence document again if the following conditions are met:

   a. The provider verifies that the document presented at the time of renewal is identical to the copy of the lawful presence already on file, and

   b. The provider makes a notation in the file that the original document was viewed again and found to be acceptable, and

   c. The provider signs and dates the notation.

This same process applies to providers who have electronically scanned client files.
This process may never be used for non-U.S. citizens. Lawful presence must be established for non-U.S. citizen applicants each time they apply for the CICP.

Section 5.14 Administrative Procedures for Documents from Non-U.S. Citizens

1. Verification of Documentation in SAVE Documentation submitted from applicants who have checked the second box on the "Affidavit for Lawful Presence, Colorado Indigent Care Program", indicating that they are not a U.S. citizen, must be verified through the federal Systematic Alien Verification for Entitlements (SAVE) web-based verification information system application. Providers must verify through SAVE within 30 days of receiving applications from non-U.S. citizens.

    a. **How to Use SAVE**: In order to assist providers, the Department has posted a PowerPoint tutorial on how to use SAVE on its website. Click on "Lawful Presence Information HB 06S-1023" to locate this tool. User access forms for SAVE are also available to providers at this site.

    b. **SAVE is Not for U.S. Citizens**: Only documents for non-U.S. citizens (numbered 30 through 50 on the reverse side of the Affidavit) may be verified for authenticity in SAVE. It is not possible to verify documents applicable to U.S. citizens through SAVE.

    c. **Use Affidavit until SAVE Verification is Complete**: Until lawful presence is confirmed in SAVE, clients are eligible to receive discounted health care services through the CICP if they have signed the Affidavit stating that they are lawfully present in the United States.

    d. **No Match Found in SAVE**: In cases where a match in SAVE is not initially verified, yet the client asserts that they are legally residing in the country, the provider should begin the manual SAVE process and conditionally accept the client until status is confirmed or denied in SAVE. This provisional period of eligibility should be granted for not less than one month, but not more than three months. The length of the provisional acceptance is at the discretion of the provider. The provider shall take into consideration any known special circumstances of the client when setting the length of the conditional eligibility period. The provider should make the client aware of any information obtained through the SAVE process.

    e. The SAVE program also requires participating agencies, institutions and other entities to use manual verification when directed by an VIS/CPS system message or when the automated check or initial inspection of an applicant's/recipient's documentation, or information provided from such documentation, reveals material discrepancies. To conduct a manual verification, user agencies complete the Document Verification Request (Form G-845), attach copies of the non-citizen's immigration documentation, and mail it to their local immigration status verification office. Providers in Colorado would mail documents and form to: U.S. Citizenship and Immigration Services, 300 N. Los Angeles Street, B120, Los Angeles, CA 90012, Attention: Immigration Status Verification Unit. Once the immigration status verification office receives and processes the Form G-845, it is returned

to the User Agency via the U.S. Postal Service.

2. **Indication of Documents Verified:** Providers are to check the box on the "For Eligibility Use Only" section of the Affidavit indicating which document the applicant has provided for demonstrating evidence of lawful presence.

3. **Retain Copy of Document:** A photocopy of the lawful presence document presented and used in the SAVE search should be retained in the applicant's file.

4. **Retain Copy of SAVE Documentation:** Providers should print the Verification Result Screen from the SAVE search and retain this printout in the applicant's case file. The provider should make the client aware of any information obtained through the SAVE process and note such in the Application file.

Section 5.15 U.S. Citizen

1. A U.S. citizen is a person who has signed the Affidavit of Lawful Presence, checking the line indicating that he/she is a U.S. citizen and provides **one** acceptable document for proving evidence of lawful presence from the list of documents numbered 1 through 29 on the reverse side of the Affidavit of Lawful Presence or one of the documents numbered 1 through 29 in this manual, Section I Eligibility, Article VI Lawful Presence.

Section 5.16 Documented Immigrants

1. Documented immigrants are people who reside in the United States and possess a Social Security Number and **one** of the) lawful presence documents listed in Article VI of this manual.

Section 5.17 Colorado Resident

1. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state. The following questions can be used to help determine if the applicant is a Colorado resident:

    a. Where is the applicant's primary home? A primary home is the place of residence where a person lives and the place where that person, whenever absent, intends to return, regardless of the length of absence. A primary home cannot be a business address or a vacant lot or a post office box.

    b. Is the applicant's primary home address the same as the address on the applicant's motor vehicle registration and state income tax return? If yes, the applicant meets the CICP's residency requirements. Individuals who have recently moved to Colorado must apply for a Colorado title and registration for their vehicle within 30 days from establishing Colorado residency.

    c. Is applicant employed in the state of Colorado?

    d. Is there a current lease, mortgage bill, or utility bill for the applicant's primary home?

e. Does the applicant have a current Colorado Driver's License or Identification Card?

Section 5.18 Migrant Workers

Migrant workers and all dependent family members must meet all of the following criteria to comply with CICP residency requirements:

1. Do not live permanently in Colorado; temporary living in Colorado for employment reasons.

2. Meet lawful presence requirements.

3. Employed in Colorado. ***Must have letter of employment.***

Eligibility is extended to dependent family members of migrant workers when the residency requirements are met for the CICP including: if the family members establish a temporary home in Colorado and meet U.S. citizenship OR meet established immigration documentation requirements. Requirement number three may not be applicable to all family members.

Section 5.19 Applicants Not Eligible for the CICP

1. **Individuals for whom lawful presence cannot be verified.**

2. **An applicant in custody of a law enforcement agency.** An individual is not eligible when they are serving time for a criminal offense or confined involuntarily in a City, County, State or Federal prison, jail, detention facility, or other penal facility. This includes individuals who are being involuntarily held in detention centers awaiting trial, involuntarily residing at a wilderness camp under any type of governmental control, and involuntarily residing in a half-way house under any type of governmental control. Even if the medical condition is considered "pre-existing" prior to incarceration, once the individual is being held involuntarily under any type of governmental control they are not eligible for CICP.

   a. Prior to Incarceration: The applicant is eligible for CICP. If an applicant has been convicted of a crime but has not reported to the penal facility to start their sentence, the applicant remains eligible for CICP.

   b. Parole or Probation after Incarceration: An applicant on parole or probation is eligible for CICP. An applicant who is living in a halfway house is eligible for CICP only if they are on parole. Most residents of a halfway house are still considered inmates and are involuntarily residing under a type of governmental control. If the applicant has not been officially released through a parole board, he/she is still considered an inmate and is therefore NOT eligible for CICP.

3. College students from outside Colorado or the United States who are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

4. Visitors from other states or countries temporarily visiting Colorado who have primary residences outside of Colorado.

5. Persons who qualify for Medicaid.

6. The CICP cannot be used as proof of college medical insurance.

7. **Persons who qualify for CHP+**. However, individuals who are waiting to become an enrollee in CHP+ and/or have incurred charges at a participating CICP Provider in the 90 days prior to the CICP Application date shall not be excluded from consideration for CICP eligibility on a temporary basis subject to the following:
   a. The temporary basis does not exceed 3 months.
   b. The applicant satisfies all of the client eligibility requirements for CICP.
   c. Once applicants become enrolled in the CHP+, they are no longer eligible for the CICP.
   d. Applicants who have been disenrolled from, but remain eligible for, the CHP+, are eligible for the CICP on a temporary basis not to exceed three months. If CHP+ determination has not been received at the end of the three-month period, the applicant may be enrolled in the CICP for an additional three months.
   e. Applicants who have been disenrolled from, and are no longer eligible for the CHP+, are eligible for the CICP and should be enrolled as regular applicants.

ARTICLE VI. FINANCIAL ELIGIBILITY (8.905)

Include with the Client's Application the full names, phone numbers and addresses of all employers and retirement payments. Income sources include payments from employment, Social Security, pension funds, unemployment compensation and self-employment. List the income sources for all family members over the age of 18. Earned income from a working minor (under the age of 18) is exempt.

Section 6.01 Determining the Applicant's Income (8.905)

The CICP administration has five methods for determining an applicant's income and establishing financial status. The methods are (in order of priority):

Line 1 - Employment Income

Line 2 - Unearned Income

Line 3 - Self-Employment

Calculate all income beginning with Line 1, "Employment Income."

When calculating income, you must obtain as much documentation as possible to substantiate amounts.

Section 6.02 Employment Income (8.905)

Employment income is income earned (including overtime and bonuses) for providing services to another individual or company. Earned income from a working minor (under the age of 18) is exempt. Employment income for CICP does not include self-employment income which is addressed separately. Documentation of employment income is a pay stub or a letter on official letterhead from the applicant's employer.

There are 3 steps to calculating current employment income.

Step 1. Obtain documentation for current month or previous months' employment income. Obtain at least one month of information, or a pay stub showing a year-to-date income figure. Complete Worksheet - 1 "Employment Income" using gross amounts. "Gross" means the dollar amount before any deductions or losses are subtracted.

Step 2. Use one of the following methods to determine the monthly gross employment income. Write the total amount of gross employment income in the monthly total column on Line 1, Section II of the Application.

Year to Date Method:

The Year-to-Date Method of calculating annualized gross income utilizes the applicants cumulative year-to-date gross earnings on the pay stub. When utilizing this method, the applicant will need to provide their **most current year-to-date paystub**. It is not required to request a full month of paystubs

when utilizing this method. To determine the annualized income, count the number of pay periods that have occurred since January 1, then divide that number into the gross year-to-date earnings indicated on the pay stub. The result of this computation is then multiplied by the number of pay periods in a year to determine the annualized gross earnings.

Example:

The applicant provides you with a recent pay stub whose year-to-date earnings are $13,756. The pay frequency is bi-weekly. The pay period ended September 30th and since January 1st the applicant has been paid 19 times. The calculation would be as follows:

Divide $13,756 by 19 bi-weekly pay periods = $724.00
Multiply $724 by 26 bi-weekly pay periods in a year = $18,824
OR
Divide $13,756 by 38 weekly pay periods = $362.00
Multiply $362 by 52 weekly pay periods in a year= $18,824

Average Pay Method:

The Average Pay method of calculating income utilizes the average gross earnings based upon the number of pay stubs provided. When utilizing this method the applicant will need to provide at least a full month of paystubs. To determine the average gross earnings, total all the gross earnings of all the pay stubs provided and divide the result by the number of pay stubs. The result will be the average gross earnings per pay period. Next, determine if the applicant is paid weekly, bi-weekly or semi-monthly (usually the 1st & 15th). Convert the average gross earnings to monthly income.

1. To convert weekly income to monthly income, multiply by 4.333
2. To convert bi-weekly income to monthly income, multiply by 2.1666
3. To convert semi-monthly income to monthly income, multiply by 2

Lastly, annualize the average monthly gross earnings.

Example:

An applicant provides you with six pay stubs with gross earnings of $534.00, $475.00, $398.00, $534.00, $498.00 and $534.00. The pay frequency is weekly. The calculation would be as follows:

Add: $534.00, $475.00, $398.00, $534.00, $498.00 and $534.00 = $2,973.00
Divide: $2,973.00 by 6 pay stubs = $495.50 average weekly gross earnings
Multiply $495.50 by 4.333 = $2,147.00
Multiply $2147.00 by 12 months = $25,764.00

Monthly Pay Method

The monthly pay method of calculating income utilizes the most recent monthly pay stub. Utilize the monthly income and annualize.

Step 3. Write the annualized total income from Step 2 on Line 1 in the "Annualized Total" column of the Application

Section 6.03 Unearned Income (8.905)

Unearned income is countable gross cash received from sources other than employment. Complete Worksheet 1 – Employment Income and Unearned Income. Write the total amount of the unearned income on line 3 of the Application. This income can be self-declared.

1. Unemployment Compensation or Workers Compensation.

2. Old Age Pension (OAP) benefits (financial assistance to low income individuals age 60 and over).

3. Social Security payments such as, Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Social Security Retirement, Social Security Survivors benefit, Social Security Dependent benefit are countable sources of income. Any Social Security income paid to a minor (under age 18) is exempt. The provider must receive verification that the Social Security benefit is payable to the child. If the checks do not include the child's name, then include these payments in other income sources on the Application. Applicants who are Medicaid eligible cannot receive care under the CICP without providing a written Medicaid denial.

4. Payments from Retirement Plans and Pensions. Retirement plans and pensions come in many forms. Some examples are: PERA, Tax Sheltered Annuities, Deferred Compensation, Individual Retirement Accounts (IRAs), 401k plans and Social Security Benefits. Do not include Social Security Benefit payments to children when calculating other income sources on the Application.

5. Commissions, Bonuses, Gifts and Tips. Include amounts from commissions, bonuses, gifts and tips when calculating unearned income on the Application.

6. Court-Ordered Alimony Received.

7. Trust Accounts are income from other sources.

8. Income from rental properties, net of expenses incurred from rental operations, including boarding and lodging, when calculating other income sources on the Application.

9. Interest Income includes interest earnings from savings accounts, stocks, bonds and similar securities when calculating other income sources on the Application.

10. Monetary gains from selling an asset are counted as other income sources on the Application.

11. Insurance policies that are revocable (with cash surrender value).

12. Monetary settlements received not related to a medical injury accident.

Section 6.04 Exempt Unearned Income (8.905)

The following types of unearned income are ***not included*** in determining total income.

1. Aid to the Needy and Disabled (AND) payments to Medicaid clients.

2. Payments to recipients of Colorado's Aid to the Needy and Disabled (AND) financial assistance program.

3. College grants, scholarships and work-study income. Work-study income is generally awarded based on financial need and is determined by completing a Federal Student Aid Application.

4. Grants to CICP clients from non-profit, tax-exempt, charitable foundations specifically for CICP client copayments. The provider must honor these grants as CICP client copayments.

5. Child Support and Foster Care Payments. These payments are for the support of children. Many children receiving these payments are Medicaid eligible. Therefore, require a Medicaid denial before allowing these children to receive care under the CICP.

6. Food Stamps and Women, Infants, and Children (WIC).

7. Assistance provided by non-profit organizations, if the assistance is need-based (i.e., the cost of meals at a soup kitchen).

8. Medical care provided for free or if a third party made the payments.

9. Settlements received as a result of a prior medical injury; not related to the current CICP Application.

10. Reimbursement for work- related personal expenses.

11. College loans.

12. Payments by credit life or credit disability insurance.

13. Proceeds of a loan.

14. Income from a reverse mortgage.

15. Disaster relief assistance.

16. Tax refunds.

17. IRAs, pensions and insurance policies (irrevocable policies) that are not available without penalty.

18. Moving expenses paid by employer for relocation.

19. Social Security income for a minor (under the age of 18).

Section 6.05 Section 7.05 Self-Employment (8.905)

If a self-employed person pays themselves just as they would their employees, and can document by pay stubs, use the figure from the pay stub.

To determine the net profit of a self-employed applicant, deduct the cost of doing business from the gross income. To obtain the gross income, request one month of gross bank business deposits. If bank business deposits are not available, a profit and loss worksheet OR a ledger is acceptable documentation for gross income and business expenses. Gross income amount and business expenses listed on profit and loss or ledger documents should be transferred to Worksheet 2. If the applicant does not have a profit or loss worksheet or a ledger, the applicant should complete Worksheet 2 and list each business expense. Worksheet 2 must be signed, dated and attached to Application. An expense is something that is necessary to keep a business in operation.

1. Expenses can include, but are not limited to:
    - Rent of business premises
    - Wholesale cost of merchandise
    - Utilities
    - Taxes
    - Labor
    - Upkeep of necessary equipment

2. Self-employment expenses do not include:
    - Depreciation of equipment.
    - Cost of payment on principal of loans for capital assets, or durable goods.
    - Personal income tax payments, lunches, transportation to and from work, and other personal expenses.

3. Self-employed licensed, certified or approved day care providers may receive the following deductions each month to compensate for wear and tear on the residence:
    - $55 for the first child for whom day care is provided; and
    - $22 for each additional child.

    However, if the client can document a cost of doing business, which is greater than the amounts described above, use the expenses identified in Section 5.05 (1)

The IRS states that for businesses that are operating out of the home, ⅓ (one-third) of the expenses should be attributed to the business. For home expenses that can be used for personal and business purposes, designate a percent for the amount of time that a particular expense is used for the business.

Example

A subcontractor works out of his primary residence. The subcontractor's gross monthly income is $2,000. The business expenses are as follows:

Internet $45
Phone $50
Mortgage $900
Utility $100
Supplies $60

Internet $45	Subcontractor uses the internet for 75% of the business $45 multiplied by .75 = **$33.75** $33.75 is the amount used for business expense
Mortgage $900	Subcontractor works from primary residence, deduct ⅓ as expense $900 divided by 3 = **$300** $300 is the amount used for business expense
Utility $100	Subcontractor works from primary residence, deduct ⅓ as expense $100 divided by 3 = **$33.33** $33.33 is the amount used for business expense
Phone $50	Subcontractor has a separate business telephone. Count entire expense for business purposes - **$50**
Supplies $60	Subcontractor only uses supplies for business purposes. Count entire expense for business purposes - **$60**

Total Monthly Business Expenses: $477.08
Total Monthly Gross Income: $2000.00
Subtract $2000.00 - $477.08 = $1522.92 (monthly)
Annualize $1522.92 x 12 months =$18,275.04 (yearly)

Section 6.06 Current Monthly Expenses (8.905)

Effective July 1, 2010, based on a decision made by the Department and CICP stakeholders, using the "Current Monthly Expenses" method to calculate income for applicants who are unemployed is no longer valid. Unless the applicant receives Unearned Income that may be countable as gross cash received from other sources (Section 7.03), the applicant should receive an "N" rate.

Section 6.07 In-Kind Earned Income (8.905)

Effective July 1, 2010, the consideration of "In-Kind Earned Income" as a substitute for monetary payments is discontinued. The value of goods and services received by applicants should not be considered when calculating income for the individual applicant or family members.

Section 6.08 Total Income

To calculate total income for Section II of the Application, ADD "Gross Employment Income (line 1)" PLUS "Self Employment Income (Line 2)" PLUS "Unearned Income (Line 3)". Take the total from lines 1, 2, and 3, and record the amount in "Total Income (line 4)". Record the number from line 4 in "CICP Income Calculation (line 5)."

Section 6.09 Calculating Equity in Resources (8.905)

The "Calculating Equity in Resources" portion of the Application shows the amount of equity in resources available to an applicant.

1. Calculating Vehicle Equity

   For calculating the amount of vehicle equity to record on the Application, complete the following steps:

   Step 1. Determine the total value of all vehicles owned by the applicant. Write this amount on Line 6 under the "Actual Value" column. To determine the value of vehicles, request a copy of the client's vehicle registration.

   Step 2. Determine the total amount owed on all vehicles owned by the applicant. Write this amount on Line 6 under the "Amount Owed" column of the Application. You should receive confirmation (verbal or written) from the applicant's bank to confirm outstanding vehicle loans.

   Step 3. The CICP protects a total of $4,500 ("Minus Protected Portion" column) for all vehicles owned.

   Step 4. Subtract the "Amount Owed" and $4,500" **FROM** the "Actual Value" of all vehicles. Write this amount on Line 6 under the "CICP Equity Calculation" column of the Application. If this amount is less than zero (a negative amount), you must record $0 in the "CICP Equity Calculation" column.

   Vehicle Equity - Example

   An applicant has 2 vehicles. One vehicle is valued at $9,000 but the applicant owes $8,000 on this vehicle; the second vehicle is valued at $2,000 with no money owed. The "Value" is $11,000 ($9,000+$2,000). The "Amount Owed" is $8,000. Therefore, the equity is $3,000 ($11,000-$8,000) before subtracting the Protected Portion. The "Minus

Protected Portion" is always $4,500. The "Amount to Use for the CICP" is $0 since $3,000-$4,500 is -$1,500. For the CICP, you cannot record negative numbers.

2. Real Property

   Effective July 1, 2010, the value of real property such as houses or land is no longer a consideration in determining the family's equity in assets. The total value in real property should be disregarded.

3. Liquid Resources

   Liquid resources are resources that can be converted to cash immediately. Examples of liquid resources are: checking accounts, saving accounts, trust accounts (if funds are available immediately), the cash value of life insurance, short-term Certificate of Deposits (CD's) and partnership earnings kept in reserve. Retirement accounts and Tax Sheltered Annuities are liquid resources, if the applicant can draw funds out of the account without a penalty. Most retirement plans are subject to a penalty if the person withdrawing money is under the age of 59 ½.

   For applicants with a partnership (i.e. partnership in a farm), request their Federal Income Tax Schedule K-1 and Schedule E. Schedule K-1 summarizes the total amount of cash available to all partners. Schedule E shows all partnership agreements and the amount earned by the partnership. Include that amount of cash available to the applicant in the liquid resource calculation on the Application.

   For applicants with a Certificate of Deposit (CD), count the principal (amount of original investment) of a CD as a resource regardless of the maturity date of the CD. Do not subtract the penalty for an early withdrawal from the principal. If an applicant has recently cashed a CD that has reached its maturity date, count the principal in addition to the interest earned.

   The following example explains how to calculate liquid resources for the CICP. An applicant has $3,000 in savings plus they can withdraw $2,000 from a Tax Sheltered Annuity without penalty. Their total liquid resources are therefore $5,000.

   It should be made clear to applicants that liquid resources that can be made available without penalty must be used even if the applicants believe their savings are their "reserves".

4. Business Equity

   Effective July 1, 2010, equity in a business(es) owned by the applicant is no longer a consideration in determining the family's assets. Business equity should not be included in the calculation when the provider is determining the applicant's net self-employment income.

5. Total Equity in Resources

   "Total Equity in Resources" is Lines 6, and 7 of the CICP Client Application. This cannot be a negative number. If you get a negative number on either form, enter $0 (zero).

Section 6.10 Less Family Size Deductions

The CICP protects $2,500 in resource equity per family member on the Application.
There are two steps to calculating the "Family Size Deduction:"

Step 1. Write the number of family members in the applicants listed on the "Family Member Table," on the Application on Line 11 - "Family Size."

Step 2. Multiply the family size obtained in Step 1 by $2,500. Write this amount on the last blank Line of Line 11.

Section 6.11 Equity in Resources for the CICP

Line 12, "Equity in Resources for the CICP," on Line 10, "Total Equity in Resources," minus Line 11, "Less Family Size Deduction," which equals Line 12, "Equity in Resources for the CICP." If this amount is less than $0 (a negative amount), you must record $0 and not the negative amount.

Section 6.12 Total Family Financial Status (8.905)

Line 13, "Total Family Financial Status," is, Line 5, "Total Income," PLUS, Line 12, "Equity in Resources for the CICP" from the CICP Client Application. This amount cannot be zero. The amount on Line 10 or Line 13 estimates what the family will have to live on over the next 12 months.

Section 6.13 Allowable Deductions (Expenses, self-declared) (8.905)

The following are allowable deductions (expenses) and may be self-declared. Waivers may be granted from the CICP Administration to those providers who wish to require documentation. For the following expenses, request amounts paid in the past 90 days and annualize:

1. Daycare and elderly care expenses incurred by the family (this does not include vacation or entertainment expenses for these services)
2. Child support payments
3. Alimony paid by the applicant
4. Health (including dental and vision) insurance premiums

Section 6.14 Allowable Deductions (Must be Documented)

The following allowable deductions must be documented:

1. Medical expenses for services received at a hospital, clinic, private physician's office and pharmacist are allowable deductions and must be documented. In addition, allowable deductions include medical services prescribed by a physician rendered for vision, dental, durable medical equipment (DME) and pharmaceuticals.

a. The amount of medical bills if paid or outstanding from any medical provider may be deducted from the income if incurred from the Application date back 365 days. Do not annualize these figures, since the amount already is a yearly amount. All deductions must be documented.

b. The amount of medical bills if paid or outstanding from a CICP provider may not be deducted from the income if incurred within the 90 days prior to the Application date. These medical bills will be received at the CICP discount to the client and cannot be included as a deduction on the Application. Copayments to a CICP provider are not an allowable deduction.

2. Applicants who use their own personal vehicle in the course of performing their job may be allowed a deduction in the amount of $200 per month. The $200 per month personal vehicle use deduction should only be allowed if the applicant submits documentation from their employer which verifies the following:

   a. The applicant uses the personal vehicle in the performance of his or her job functions; and

   b. The applicant receives no reimbursement for mileage or the use of the vehicle.

   Acceptable documentation is a signed and dated letter from applicant's employer or the use of the CICP Administration's *Personal Vehicle Use Verification* Form found at Section VI: Client Affidavit and Application.

3. To calculate the deductions for Line 14 of the CICP Client Application, perform the following steps:

   Step 1. Request amount paid in the previous month or previous year for allowable deductions (expenses).

   Step 2. Complete Worksheet 4 for the allowable deductions.

   Step 3. Record the Grand Total on Line 14 of the CICP Client Application or Line 4 of the CICP Worksheet 1 (Calculating the Rate). Do not annualize one-time or annual payments.

Section 6.15 Net CICP Income and Equity in Resources (8.905)

Line 13 of the CICP Client Application, "Total Family Financial Status" minus Line 12 of the CICP Client Application, "Less Allowable Deductions determines Net CICP Income". Line 15, "CICP Income and Equity in Resources," is the amount to use for determining if a family qualifies for the CICP.

ARTICLE VII. CICP RATING (8.906)

The CICP rating determines a family's copayments and client copayment annual cap. CICP ratings are effective for one year from the date of the rating, unless the client's financial situation changes or the rating is a result of a provider management exception.

Any family member eligible for CHP+ may receive a CICP rating on a temporary basis for 90 days. This rating is retroactive for services received 90 days prior to the Application and valid for three months from the Application date.

"CICP Rating Box" is where you record the CICP letter rating or "Denied" for the applicant. You must assign a rating or denial and notify the applicant of his/her status within five working days of the applicant completing the Application.

The denial letter should include a statement informing the applicant that he/she has 15 days to appeal the rating. The denial letter should clearly identify to whom the letter is addressing, with an address and phone number. Family members receiving CICP discounted services under the same Application all have the same CICP rating.

CICP ratings are usually effective for 12 months from the date of the Application. Extenuating circumstances sometimes require that the rating be effective for a shorter period of time. When a client is rated for a period lesser than 12 months, it is the responsibility of the primary rating provider to perform the re-rating within the specified time.

Section 7.01 Determining the CICP Rating (8.906 A)

To determine the CICP rating, complete the following steps:

On the CICP Ability to Pay Scale locate the appropriate family size corresponding to the family size recorded on Line 11 of the Application.

Slide across the CICP Ability to Pay Scale until you find the range where the family's "Net CICP Income and Equity in Resources" (Line 15 of the Application) falls. The letter rating at the top of this column is the family's CICP rating.

The letter codes mean the following:

> **N** = 40% of the Federal Poverty Level (FPL), families rated at this level should be referred to Medicaid before CICP is considered.
>
> **A, B, C** = Families falling within this rating are up to 100% of FPL and should also be referred to Medicaid.
>
> Single adults who fall within the first 4 ratings and are not pregnant may not be eligible for Medicaid.

Women rated at the **D** and **E** level **and who are pregnant are possibly eligible for Medicaid or other entitlement programs**. Refer those women to Medicaid and require them to have a denial letter prior to participating in the CICP.

F, **G, H, and I** = Families not eligible for Medicaid. However, children and pregnant women age 19 and over should be referred to CHP+.

Z = The following individuals at or below 40% of FPL: Effective July 1, 2008, homeless individuals, or individuals living in transitional housing designed to promote self-sufficiency, or individuals who have no permanent residence of their own and are temporarily residing with others who have no legal obligation to financially support them, or recipients of Colorado's Aid to the Needy Disabled financial assistance program. There is no copayment required for this rating.

Record the family's CICP rating in the "CICP Rating" box of the Application. If the family does not qualify for the CICP, write "Denied" in the "CICP Rating" box of the Application.

Give the family a copy of the completed Application.

Example: The family completing the Application has 5 family members, as documented on Line 12 of the Application. The family's "Net CICP Income and Equity in Resources" figure is $27,955, as documented on Line 16 of the Application. Turn to the "CICP Ability to Pay Scale" in this Manual. In the "Family Size" column, find 5. Go across the scale until you are in the $27,379 to $31,122 range. The family's income is within this range ($27,955). Record an "E" as the family's CICP rating in the "CICP Rating Box" of the Application.

Section 7.02 Client Re-rate (8.906 B)

Clients are re-rated when their financial situation has changed since the initial rating. Client re-ratings affect only future charges. Therefore, bills incurred after the initial rating but prior to the re-rating are discounted based on the client's initial rating.

When clients request a re-rating and can document that their circumstances have changed since the initial rating, you must re-rate them. Reasons for a re-rating to occur may include one or more of the following:

1. Family income has changed significantly;
2. Number of dependents has changed;
3. An error in the calculation; OR
4. The year rate has expired

ARTICLE VIII. CLIENT COPAYMENT (8.907)

Section 8.01 Client Annual Copayment and Cap (8.907 A)

For all client ratings except those with an N-rating, annual copayments for CICP clients cannot exceed 10% of the family's "Total CICP Income and Equity in Resources," recorded on Line 15 of the Application. Annual copayments for clients with N-ratings cannot exceed $120.

The CICP Client Annual Copayment Cap (annual cap) is based on a calendar year (January 1 through December 31), even if a client's rating is for a different year (i.e., April 1 through March 31). Clients are responsible for any charges incurred prior to receiving their CICP rating. Clients are responsible for tracking their copayments and informing the provider in writing (including documentation) when they meet their annual cap. However, if clients overpay their annual cap and inform the provider in writing, the provider's facility must reimburse the client for the amount overpaid.

The client's annual cap can change during the calendar year if the client is rated again. All copayments made toward the old annual cap during the calendar year apply to the new cap. The annual cap amount starts completely over again on January 1st. If a client is admitted to the hospital in December and discharged in January, copayments will be collected in a new calendar year. Therefore, the client's copayment made for the discharge in January applies to the new calendar year's annual cap.

If a client is re-rated during the calendar year, the client is given a lower CICP rating, and the client has made copayments that now exceed the new, lower annual cap, the provider is not required to refund the excess copayments received. If during the re-rating process, the client receives a higher CICP rating, the provider should collect copayments up to the new, higher annual cap for the calendar year.

Annual caps apply to charges incurred only after a client is eligible for the CICP, and apply only to services incurred at a CICP provider. For example: A client received services from a provider's facility in March and did not qualify for the CICP. In November, the client receives services from a provider's facility and does qualify for the CICP. Payments made by the client for the services received in March do not apply to the annual cap.

Sometimes clients want to prepay their annual cap prior to receiving services. The CICP Administration does not support this practice because if the client does not incur charges equal to the prepaid copayment cap, the provider's facility will need to refund the overpayment to the client.

Section 8.02 Calculating the CICP Client Copayment Annual Cap (8.907 C)

To calculate the "CICP Client Copayment Annual Cap," multiply Line 15 of the Application by 0.10 (10%). (Do not round Line 16 up to the next highest dollar amount.) Enter this amount on the "Annual Cap" Line in the Client Copayment box.

Example: In February, a family of four applies for the CICP. Their "Net CICP Income and Equity in Resources," Line 16, is $12,000. Their CICP rating is "B." Their CICP annual cap is $1,200 ($12,000 x 0.10). By July, the family has paid $300 in copayments. The mother loses her job in June, so the family is re-rated. Their new income is $10,000. Their new CICP rating is "A," and their new annual cap is $1,000 ($10,000 x 0.10). The family is still responsible for $700 ($1000 new annual cap minus $300 copayments already paid) in copayments for the calendar year.

Section 8.03 Client Copayments - General Policies (8.907 A)

CICP clients are responsible for paying a portion of their medical bills. The client's portion is called the "client copayment." CICP providers must charge each CICP client a copayment. The CICP Administration recommends that CICP providers require clients to pay their copayment prior to receiving care (except emergent care). For the CICP, there are different copayments for different service charges. The following information explains the different types of medical care charges and the related client copayments:

1. Hospital inpatient facility charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay longer than 24 hours. The client is responsible for the corresponding Hospital Inpatient Copayment.
2. Hospital outpatient charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care). The client is responsible for the corresponding Hospital Emergency Room Copayment.
3. Physician charges are for services provided to a client by a physician in the hospital setting, including emergency room care. The client is responsible for the corresponding Physician Copayment. Please advise clients that they are responsible for these copayments in addition to the inpatient stay copayment and the emergency room visit copayment. Moreover, if CICP clients are being treated in your facility by physicians who are not under contract with you to receive CICP reimbursement, clients should be notified in advance that these physicians do not accept CICP and that the client will be responsible for all charges.
4. Outpatient charges are for all non-physician (facility) and physician services received by a client while receiving care in the outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Outpatient charges include primary and preventive medical care. The client is responsible for the corresponding Outpatient Clinic Copayment.
5. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a client while receiving care in the specialty outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Specialty Outpatient charges include distinctive medical care (i.e. oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. The client is responsible for the corresponding Specialty Outpatient Clinic Copayment. A qualified health care

provider must receive written approval from the Department to charge the Specialty Outpatient Clinic Copayment.

6. Laboratory Service charges are for all laboratory tests received by a client not associated with an inpatient facility or hospital outpatient charge during the same period. The client is responsible for the corresponding Laboratory Services Copayment.
7. Prescription charges are for prescription drugs received by a client at a qualified health care provider's pharmacy as an outpatient service. The client is responsible for the corresponding Prescription Copayment. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.
8. Ambulatory Surgery charges are for all operative procedures received by a client who is admitted to and discharged from the hospital setting on the same day. The client is responsible for the corresponding Inpatient Hospital Copayment for the non-physician (facility) services and the corresponding Physician Copayment for the physician services.
9. The client is responsible for the corresponding Hospital Inpatient Copayment for Magnetic Resonance Imaging (MRI), Computed Tomography (CT) and nuclear medicine services received by the client.
10. If a client is in the hospital for more than 24 hours, the Hospital Inpatient copayment is charged. If a client is in the hospital for less than 24 hours, the Hospital Emergency Room copayment is charged, unless one of the following procedures takes places: ambulatory surgery, MRI, CT Scan, PET/CT Scan or Nuclear Medicine, in which then the Hospital Inpatient copayment is charged.
11. Z-Rating. Effective July 1, 2008, The Z-Rating is no longer limited to only homeless clients. The Z-Rating has been expanded to encompass clients who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating) and are homeless, living in transitional housing, temporarily residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program.
    a. Homeless clients are exempt from client copayments. Homeless patients are also exempt from the income verification requirement, verification of denied Medicaid benefits requirement, and providing proof of residency when completing the CICP Application.
    b. Transitional housing clients are clients who are participating in programs (other than those excluded in Article VI, Section 6.09 of this manual) designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing clients are exempt from client copayments. In addition, transitional housing clients are exempt from the income verification and verification of denied Medicaid benefits requirements when completing the CICP Application.
    c. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the client are exempt from client copayments. The individual allowing the client to reside with him or her may be asked to provide a written statement confirming that the client is not

providing financial assistance to the household and that the living arrangement is *not intended* to be permanent. Clients residing with others are exempt from the verification of denied Medicaid benefits requirement when completing the CICP Application. Clients residing with others are NOT exempt from the income verification requirement.

d. Recipients of Colorado's Aid to the Needy Disabled (AND) financial assistance program who are eligible and enrolled to receive the monthly grant award are exempt from client copayments. In addition, recipients of Colorado's Aid to the Needy Disabled (AND) financial assistance program are exempt from the income verification and verification of denied Medicaid benefits requirements when completing the CICP Application.

Section 8.04 Determining a Client's Copayment (8.907 D)

Using the client rating recorded in the "CICP Rating Box," look up the corresponding rating on the "CICP Client Copayment Table". The copayment amount is listed by service.

Section 8.05 Responsible Party Signature

The responsible party listed on the first line of the Application must sign the Application within 90 days of the date of service. If an applicant is unable to sign the Application or has died, a spouse, relative or guardian can sign the Application. An unsigned Application means the Application has not been completed, the applicant cannot receive a discount for services under the Program, and the applicant has no appeal rights. The Application must be completed before the responsible party can sign.

The prospective client has 15 days to provide requested information. The Application completion process must be completed within 45 days. If requested documentation is not provided by the applicant, the provider has the right to deny CICP eligibility. The client has a right to obtain a copy of the completed Application.

Section 8.06 CICP Policy on Fraudulent Applications

Clients should be notified of the following State Statutes prior to signing the CICP Application:

Any person who represents that any medical service is reimbursable or subject to payment under this article when he or she knows that it is not and any person who represents that he or she is eligible for assistance under this article when he or she knows that he or she is not commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

C.R.S. 18-5-102 - Forgery

1. A person commits forgery, if, with intent to defraud, such person falsely makes, completes, alters, or utters a written instrument which is or purports to be, or which is calculated to become or to represent if completed:

a. A written instrument officially issued or created by a public office, public servant or government agency.

2. Forgery is a class 5 felony.

C.R.S. 18-1-105 Felonies classified - presumptive penalties

Class 5 Felonies carry a minimum sentence of one-year imprisonment up to a maximum sentence of three years imprisonment with a mandatory period of parole of two years. In addition, a minimum fine of one thousand dollars up to a maximum fine of one hundred thousand dollars may be imposed.

C.R.S 18-5-114 - Offering a false instrument for recording

1. A person commits offering a false instrument for recording in the first degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, and with intent to defraud, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.
2. Offering a false instrument for recording in the first degree is a class 5 felony.
3. A person commits offering a false instrument for recording in the second degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.
4. Offering a false instrument for recording in the second degree is a class 1 misdemeanor.

Reporting fraud is the responsibility of the provider who completed the CICP Application for the implicated client.

If a provider is notified that a client has possibly committed fraud on a CICP Application, that provider is responsible for notifying the District Attorney of the client's county of residence, in writing. The provider should not turn over the CICP Application, medical records or billing records without a direct request from the District Attorney. The CICP Application is property of the State, stored and maintained by the provider. If the District Attorney requests the CICP Application, that Application and all supporting documentation must be provided.

If the provider is notified that a client has possibly committed fraud on a CICP Application, but that provider did not complete the CICP Application, that provider is responsible for notifying the CICP provider who did complete the Application of the report. That notification should be in writing.

The CICP Administration should be copied on all correspondence. The CICP Administration has been directed to assist all inquiries from the District Attorney, but will not submit any formal request for an investigation to the District Attorney. There is no State Agency with the authority to investigate fraud on the CICP Application.

Once the provider has notified the District Attorney, the provider is not responsible for any further action unless requested the District Attorney or the CICP Administration.

If the provider receives any reimbursement on a claim previously reimbursed by the CICP due to fraud, or any other reason, the provider must notify the CICP Administration in accordance with the CICP Manual. (See Section II: Data Collection, Article VII. Previously Charged Claim Adjustments

ARTICLE IX. APPEAL PROCESS (8.908)

Section 9.01 Re-rating

To re-rate a client, you must complete a new CICP Application.

Sometimes even though clients' financial situations may not have changed, they feel their initial ratings do not accurately reflect their current financial situations. The CICP has several methods for changing a CICP client's initial rating. The methods are listed in order below:

1. Provider Management Appeal, Section 9.03
2. Provider Management Exception, Section 9.04

Section 9.02 Instructions for Filing an Appeal (8.908 B)

You must inform the client that they have the right to appeal if they are not satisfied with the rating. All appeals must be handled at the provider level. For example, the client must receive a written denial for a provider management appeal and management exception. A client can request a provider management appeal and/or exception in the same letter. Each of these methods requires the clients to submit a written request and provide documentation supporting the reasons for the request.

Section 9.03 Provider Management Appeals (8.908 C)

A Provider Management Appeal means that an eligibility technician at your facility has found that the client's initial rating was inaccurate. Provider Management Appeals can result in higher or lower ratings depending on the documentation. A client has 15 days from the date of completing the Application to request a Provider Management Appeal. If this time frame is not met and there was not a death in the client's immediate family, you do not have to review a Provider Management Appeal. However, please notify the client that the Provider Management Appeal was denied because the client did not submit the request by the deadline.

A client can request a Provider Management Appeal for the following reasons:

1. The initial rating contains inaccurate information or miscalculations because the family member or representative was uninformed, OR

2. Miscommunication between the client and the rating technician caused incomplete or inaccurate data to be recorded on the Application.

Each provider must designate a manager to review client appeals and grant management exceptions. A provider management appeal involves receiving a written request from the client and reviewing the Application completed by the rating technician, including all back-up documentation, to determine if the CICP Application is accurate. Your facility must notify clients in writing of the results of provider management appeals within 15 working days of receipt of the appeal request from the client.

If the designated manager finds that the initial Application is not accurate, the designated manager must correct the Application and assign the correct rating to the client. The correct rating is effective retroactive to the initial date of Application. This means that charges incurred 90 days prior to the initial date of Application must be discounted. If the initial Application is accurate, the designated manager may grant a management exception to the client.

Section 9.04 Provider Management Exception (8.908 D)

A provider management exception means that the client has an unusual circumstance. Provider management exceptions must always result in a lower client rating. **Provider management exceptions should not be used for applicants who do not qualify for the CICP because their resources exceed the limit (as an example, applicants earning $100 over income limit).** Clients can either request provider management exceptions when requesting a provider management appeal or within 15 days from receipt of a provider management appeal notice. If this time frame is not met, the provider does not have to review the provider management exception request. However, please notify the client in writing that the provider management exception was denied because the client did not submit the request by the deadline.

Your facility must notify clients in writing of the results of provider management exceptions within 15 working days of receipt of the exception request from the client.

Designated managers can authorize a three-month exception to a client's rating based on unusual circumstances. After the 90-day period ends, the client must be re-rated. You must note provider management exceptions on the Application and the designated manager must initial the Application. The number of provider management exceptions granted by a provider cannot exceed 5% of all ratings performed. Providers must treat clients equitably in the provider management exception process.

Ratings from a provider management exception are effective retroactive to the initial date of Application. This means that charges incurred 90 days prior to the initial date of Application must be discounted. CICP providers do not need to honor exceptions made by other CICP providers.

Section 9.05 CICP Administration Appeals (8.908)

The Department has determined that the CICP is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the CICP is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but **will not be significantly involved in any health care decisions involving a qualified health care provider or client**.

HIPAA prevents the CICP Administration from being involved in client issues due to the Personal Health Information (PHI) clause. Each provider should establish procedures at their facility that sets forth the manner for handling appeals. The applicant should also be notified of these procedures.